9TH ANNUAL REPORT

2006
JANUARY

Maryland Commercial HMOs and POS Plans: REPORT TO POLICY MAKERS

MHCC
MARYLAND
HEALTH CARE
COMMISSION

ABOUT THE MARYLAND HEALTH CARE COMMISSION

The Maryland Health Care Commission (MHCC) is a public, regulatory commission appointed by the Governor with the advice and consent of the Maryland Senate. A primary charge of the Commission is to evaluate and publish findings on the quality and performance of commercial HMOs, nursing homes, hospitals, and ambulatory surgery facilities that operate in Maryland. MHCC produces this report annually with the cooperation of Maryland HMOs and their members. These annual performance reports are the only source of objective, independently audited information on the quality of Maryland commercial HMOs. More information about MHCC and performance reports is available at **http://mhcc.maryland.gov/consumerinfo/**.

Maryland Commercial HMOs and POS Plans: Report to Policy Makers is published by the Maryland Health Care Commission.
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ABOUT THIS REPORT

The State of Maryland assesses the performance of Maryland's commercial HMOs and their affiliated point of service (POS) plans in an effort to provide information that supports continuous improvement in the quality of health care provided to Marylanders. Quality information benefits:

- **Marylanders**, who can optimize their plan selection by using independent, comparative assessments of care delivery for their specific situation.
- **Employers**, who can make value-based health plan choices.
- **Policy makers**, who can evaluate trends within the delivery system.

This report contains information on recent trends in health care delivery: prevention; health information technology; and quality incentive programs. It also compares health plan performance across a range of health care topics: member satisfaction; preventive care at different life stages; diabetes care; asthma management; cardiovascular care; and behavioral health care. Throughout the report, "Public Health Focus" segments highlight points of interest relevant to these topics.

The goals of the *Maryland Commercial HMOs & POS Plans: Report to Policy Makers* report are to:

- Assess the aggregate performance of Maryland HMOs and POS plans in comparison with the performance of commercial HMOs and POS plans in the Mid-Atlantic region and the nation.
- Assess aggregate performance over time for Maryland commercial HMOs.
- Identify and analyze issues of particular relevance to health policy development and improve the quality of managed care in Maryland.

Introduction

MARYLAND HEALTH PLANS

This report is based on data submitted by the seven health plans in Maryland that are required to report performance measurement results. With the exception of one plan, the information is an aggregate of each plan's combined performance for its HMO and POS products operating under its HMO license. For each plan required to report performance results to the Maryland Health Care Commission, Table 1 shows the average enrollment during 2004 and enrollment distribution among HMO and POS products.

Table 1: 2004 Commercial HMO/POS Enrollment

Health Plan	Number of Plan Members	% of Members Enrolled in HMO	% of Members Enrolled in POS
Aetna Health Inc.—Maryland, DC, and Virginia **(Aetna)**	337,317	87%	13%
CareFirst BlueChoice, Inc. **(BlueChoice)**[a]	494,693	56%	44%
CIGNA HealthCare Mid-Atlantic, Inc. **(CIGNA)**	152,160	66%	34%
Coventry Health Care of Delaware, Inc. **(Coventry)**	97,586	89%	11%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. **(Kaiser Permanente)**[b]	444,088	97%	3%
MD-Individual Practice Association, Inc. **(M.D. IPA)**[c]	243,659	85%	15%
Optimum Choice, Inc. **(OCI)**[c]	521,886	82%	18%

a **BlueChoice**, a for-profit HMO, operates under a holding company called CareFirst.
b **Kaiser Permanente's** performance in this report relates to HMO members only. It is the only non-profit HMO operating in Maryland.
c Two for-profit HMOs, **M.D. IPA** and **OCI**, are owned and operated by **Mid-Atlantic Medical Services, LLC. (MAMSI)**, a regional holding company and subsidiary of UnitedHealth Group, Inc.

KEY FINDINGS

Over five years (2001–2005) Maryland plan performance improved significantly on only 12 of 34 measures of clinical care and 1 of 4 member satisfaction measures. In 2005, Maryland plans, overall, performed better than the national average on 19 measures and worse than the national average on 5 measures. However, Maryland fared less well in comparison to the mid-Atlantic states. Maryland average plan performance exceeded the regional average for the mid-Atlantic states on only 6 measures.

Figure 1: Overview of Maryland's Performance Compared to the Region and Nation, 2005

Maryland's Scores Compared To:	Number of Measures That Are:	
	Below Average	Above Average
Region	13	6
Nation	5	19

Below is a list of measures that were statistically lower or higher than both the region and nation in 2005. For the second year, Maryland plans lag behind the region and nation for the same two member satisfaction measures and one behavioral health care measure. Maryland plans were higher than both the region and the nation for five measures, three more than in 2004.

LOWER

- Rating of Health Care
- Getting Care Quickly
- Follow-Up After Hospitalization for Mental Illness (Within 30 Days)

HIGHER

- Chlamydia Screening (Ages 16–25)
- Colorectal Screening
- Advising Smokers to Quit
- Diabetes Care: Eye Exams and Cholesterol Control (<100 mg/dL)
- Appropriate Medications for Adults with Asthma (Ages 18–56)

A summary of the statistically significant performance trends for Maryland plans is listed on page 6 of this report. Detailed measure results start on page 9.

Preventive Health Care

THE VALUE OF PREVENTIVE CARE

Despite the effectiveness of preventive care interventions such as smoking cessation, cancer screening, immunizations, and management of chronic diseases through behavioral changes, the American health care system continues to invest its funds and energies into treating acute health problems. The current focus on expensive treatments for disease complications has driven up the cost of health care that preventive actions could otherwise mitigate. Forecasts of the future cost burden look bleak as the number of people with chronic conditions will likely increase. In 2005, 133 million Americans have one or more chronic conditions. This is projected to increase by over one percent per year through 2030. Chronic diseases account for 83 percent in health care spending each year (Partnership for Solutions, 2004).

PREVENTION WORKS

There is strong evidence that the morbidity and mortality associated with chronic diseases can be reduced through individual healthy behaviors, lifestyle choices, and regular screenings. According to United States Department of Health and Human Services (2003):

- Regular screening for colorectal cancer can reduce the number of people who die of this disease by at least 30 percent.
- Regular mammograms can dramatically reduce a woman's risk of dying of breast cancer. A mammogram every 1–2 years can reduce this risk by about 16 percent for women 40 years of age and older.
- Preventive care can benefit the 17 million Americans with type 1 or type 2 diabetes. Research has shown that improved glycemic (blood sugar) control, leading to a 1 percent reduction in levels of A1C blood tests, reduces the risk of developing diabetic complications (eye, kidney, and nerve disease) by 40 percent. Regular eye exams and timely treatment could prevent up to 90 percent of diabetes-related blindness. Health care services that include regular foot examinations and patient education could prevent up to 85 percent of diabetes-related amputations.
- People who are obese (body mass index [BMI] >30) have a 50–100 percent greater risk of premature death from all causes than do people at a healthy weight. Lifestyle changes in diet and exercise to promote losses of 5–7 percent in body weight can prevent or delay the onset of type 2 diabetes, heart disease, and other chronic conditions.

PREVENTION OPPORTUNITIES

Adopting healthy behaviors is much easier if supportive community norms and health policies are established. In response, the Centers for Disease Control and Prevention developed the Task Force of Community Preventive Services, a 15-member non-Federal task force. In 2001, the Task Force identified six interventions effective in increasing activity levels within a community: (1) large-scale, high-intensity, community-wide campaigns with sustained visibility; (2) point-of-decision prompts encouraging people to use the stairs; (3) individually adapted health behavior change programs; (4) school-based physical education; (5) social support interventions in community settings; and (6) enhanced access to places for physical activity combined with informational outreach activities (U.S. Department of Health and Human Services, 2003).

The overall increase in the cost of health care, the rapid aging of the population, and technical advances in health services require public health professionals, health care providers, and policymaking bodies to collaborate to provide high-quality, cost-effective public health services within communities.

BARRIERS TO PREVENTION

In order for prevention to be effective, a preventive program has to overcome actual or perceived barriers and be workable in real-world conditions. These barriers may involve the health care professionals, patients, or the health care system.

- **Health Care Professionals** are often trained to focus on providing acute care over preventive care. Also, there can be an uncertainty as a result of conflicting recommendations, a perceived lack of time, a lack of interest, or low reimbursement rates from health insurance companies for preventive services (Cornuz et al, 2000).
- **Patients** may lack knowledge of preventive services needed or be unable to afford preventive screenings and treatments. Patients may doubt that, without symptoms, a disease can be detected or that anything can or should be done about it. Also, the mass media often gives conflicting messages about what preventive care is needed and how lifestyle actually affects health (Merck, 2004).
- The **Health Care System** often lacks organization and processes that promote prevention. Medical records may be disorganized or there may be an inadequate system to determine which patient needs what type of preventive services. With people moving or changing health plans, it may be difficult to assess what preventive care a patient has received. Also, there is variation in the preventive services covered by health insurance (Merck, 2004).

Prevention in Maryland

In 2001 the Maryland Department of Health and Mental Hygiene launched *A Smart Step Forward*, which is a program to create more walkable environments through changes to land use codes, implementation of demonstration projects, and community support. By encouraging more physical activity, *A Smart Step Forward* continues to seek to address serious public health concerns such as cardiovascular disease, diabetes, asthma, and obesity (National Center for Smart Growth Research and Education, 2003).

Health Information Technology

HIT: ADVANCING HEALTH CARE QUALITY

In April 2004, President Bush presented a vision for integrating health care information technology (HIT) into the daily practice of medicine. In creating the Office of the National Coordinator for Health Information Technology (see **http://www.hhs.gov/healthit/**), the administration recognized that health care lags behind other industries in the adoption of information technology by as much as 10–15 years (*The Economist*, 2003). At the end of the 1990s, most industries spent about $8,000 per worker for information technology, but the health care industry was investing only about $1,000 per worker. Most health care providers lack the information systems necessary to coordinate a patient's care with other providers, monitor compliance with prevention and disease-management guidelines, and improve performance through measurement (RAND, 2005). HIT includes a variety of integrated information resources such as electronic medical records, clinical decision support systems, and computerized ordering of prescription medications. Use of this technology serves as an essential tool for improving the quality and efficiency of health care operations. HIT delivers safety, efficiency, and resource conservation.

Electronic Medical Records:

- Disease prevention efforts are supported by scanning patient medical records for risk factors and recommending appropriate preventive services, such as vaccinations and screenings. This technology can integrate evidence-based recommendations for preventive services (such as screening exams) with patient data (such as age, sex, and family history) to identify patients needing specific services.
- Automated medical record information can make it easier for consumers to get coordinated care from different physicians by improving physician access to medical histories and lab results as patients move through the health care delivery system.

Clinical Decision Support Systems:

- Chronic disease management is aided by systems that identify patients who need tests and services and that ensure consistent recording of results. These systems can remind a physician to offer a recommended service or test during a routine patient visit and reminders can be sent to patients to schedule care.

Computerized Physician-Order Entry Systems for Medications:

- Prescription safety is a growing concern. Order entry systems increase patient safety through alerts and reminders. For example, physicians and pharmacies can be alerted about potential adverse reactions with patients' medications. Implementing these systems would eliminate approximately 200,000 adverse drug events each year, at an annual saving of about $1 billion (Hillstead, 2005).

REDUCING THE COST OF CARE USING HIT

Efficiency in the health care system increases when the same work is performed with fewer resources. Some ways in which HIT has the potential to make health care more efficient, and thus reduce the cost of services, include:

- improving workflow, practice management, and billing;
- reducing expenses associated with record keeping (filing and retrieving paper medical records), privacy regulations, and accreditation standards;
- automating information sharing among providers and patients and thereby avoiding duplicate tests;
- reducing office visits (to receive test results) and hospital admissions (occasioned by missing information); and
- reducing incidence of medical errors and malpractice suits (Goldschmidt, 2005).

Adoption of HIT within inpatient and outpatient care could result in an average annual saving of $77 billion due to efficiency improvements — largely through reduced hospital stays, reduced nurses' administrative time, and more efficient drug utilization (RAND, 2005).

Health Information Technology in Maryland

Maryland physicians use a computerized system called **ImmuNet** to track immunizations of children in the Maryland health care system. ImmuNet (**http://www.cha.state.md.us/mdimmunet/index.html**) was created by the legislature in 2001. Currently, it contains over 475,000 immunization records. The information is kept private and safe, and only registered doctors of the system have access.

ImmuNet improves quality of care and prevents disease through tracking immunizations and:

- providing Maryland physicians with access to patients' complete vaccination history
- tracking vaccination records from different doctors so that children are not vaccinated more often than they need to be
- sending a reminder to patients when it is time for a vaccination.

Quality Incentive Programs

PAY FOR PERFORMANCE

Pay-for-performance (P4P) programs, which may be sponsored by health plans, private purchasers, or government agencies, are designed to reward physicians who achieve target levels of performance on evidence-based clinical measures, member satisfaction measures, or integration of health information technology. P4P is a strategy that responds to the Institute of Medicine's (IOM) recommendation for improving the health care system. In its 2001 report entitled "Crossing the Quality Chasm," the IOM said payments for care should be redesigned to encourage providers to make positive changes to their care processes.

Using uniform quality performance metrics, P4P programs seek to realign incentives around higher quality through investments in process improvements, reductions in waste and inefficiencies, and increased accountability through comparative and public performance measurement. Programs focus on both preventive care and chronic disease management as essential components of improving the quality of health care. Many explicitly reward the use of HIT because of its importance in improving health care quality and efficiency.

Currently there are 107 active provider P4P sponsors nationwide representing over 50 million members with 95 percent of these programs targeting primary care physicians (Med-Vantage, 2005).

P4P QUALITY INCENTIVES

The actual monetary award given to physicians can vary in both type and amount, and may be substantial. The two most common incentives are quality bonuses (physician receives an annual bonus for meeting performance targets) and reimbursement at risk (health plan withholds 5 to 10 percent of reimbursement and pays it back to the physician for meeting minimum requirements). Physicians prefer quality bonus programs because they offer no financial risk.

For 2005, the average maximum physician bonus was 9 percent, with some P4P programs offering as much as 15–20 percent (Med-Vantage, 2005).

Because P4P programs encourage physicians to collect accurate data, report data, and compare their data to standards, there is a strong incentive to improve quality in order to be rewarded. Some physicians and practices may have to improve their health technology, adopting better ways to collect data such as electronic medical records or registries. Others may be able to improve quality simply by examining how routine clinical decisions are made at the point of care and modifying office protocols. The process of standardized measurement and comparison to benchmarks and peers is often an eye opener for practitioners who have not systematically examined the patterns of care in their practices. P4P offers a way of motivating this type of self-examination while offering the tangible benefits of financial rewards for improvement and high performance.

Examples of Pay-For-Performance Programs

Bridges to Excellence (BTE, see **www.bridgestoexcellence.org**) is an employer-led P4P initiative operational in Boston, Albany, NY, Cincinnati, and Louisville. In 2005 BTE announced new initiatives in collaboration with Medicare, several business coalitions, and health plans including CareFirst BlueCross BlueShield to bring P4P to additional markets including Maryland. Physicians qualify for bonus payments from the employers by surpassing designated quality benchmarks in diabetes care, cardiac care, and implementation of HIT processes. Recent evaluation results found that:

- BTE-certified endocrinologists had annual costs $370 less per patient than non-certified endocrinologists, largely because of a reduction in inpatient expenditures (Ingenix, 2005).
- Patients who saw BTE-certified endocrinologists had annual costs of $468 less than patients who saw non-certified endocrinologists (Ingenix, 2005).

The California Integrated Healthcare Association (IHA, see **www.iha.org**) is a state-wide collaborative of health plans, medical groups, and other stakeholders that runs a P4P program. The program features performance results at the medical group level (by aggregating data across multiple health plans), incentives based in part on the adoption of information technology, and production of a single public scorecard comparing the performance of medical groups. Two years of data on over 200 medical groups representing over 6 million patients shows:

- Quality improved in nearly every clinical measure (asthma, diabetes, childhood immunizations, cancer screening, and cholesterol management).
- Medical groups scoring the highest on the HIT measures consistently scored higher on both clinical and member satisfaction measures.

Trend Summary of Maryland Commercial HMO/POS Plan Performance

Table 2 below highlights HEDIS clinical and CAHPS survey measures for which there is a statistically significant change in the Maryland average from 2001 to 2005. Of the 38 measures in this report, 13 measures identified below demonstrated improvements over the five-year period.

The remaining 25 measures showed no significant changes in performance over time, and none of the measures showed a significant decrease in the average rates. A significant change means that the change was very unlikely to have occurred due to chance variation.

Table 2: Five-Year Comparison of Maryland HMO/POS Performance (2001–2005)

Measure	2001	2002	2003	2004	2005	Change 2001–2005
CHILDREN'S PREVENTIVE CARE						
Adolescents Immunization Status (Combo 2)	23.2%	27.0%	36.9%	47.9%	53.1%	29.9
Childhood Immunization Status (Combo 2)	65.6%	66.0%	71.7%	75.4%	77.1%	11.5
Children's Access to Primary Care Practitioners (Ages 12 months–24 months)	95.7%	97.0%	96.0%	96.9%	97.3%	1.6
ADULT'S PREVENTIVE HEALTH						
Prenatal Care	82.6%	84.9%	84.5%	89.6%	92.5%	9.9
Postpartum Care	75.7%	78.1%	77.1%	80.7%	82.8%	7.1
DIABETES CARE						
Cholesterol Control (LDL-C<130 mg/dL Control)	43.1%	52.1%	56.8%	64.2%	69.3%	26.2
Cholesterol Testing	77.0%	83.5%	88.5%	88.8%	91.0%	14.0
Blood Glucose Testing	77.3%	81.3%	84.4%	82.9%	84.9%	7.6
CARDIOVASCULAR CARE						
Cholesterol Management (LDL-C <130 mg/dL Control)	50.9%	56.7%	59.0%	67.5%	71.8%	20.9
Cholesterol Management (LDL-C Screening)	71.6%	73.9%	76.2%	78.7%	81.4%	9.8
ASTHMA MANAGEMENT						
Appropriate Medications for Children with Asthma (Ages 5–17)	58.9%	64.3%	66.4%	68.7%	72.8%	13.9
Appropriate Medications for Adults with Asthma (Ages 18–56)	63.1%	62.6%	70.9%	73.5%	76.4%	13.3
MEMBER SATISFACTION						
Few Consumer Complaints	78.2%	82.9%	83.8%	85.7%	86.3%	8.1

KEY HIGHLIGHTS OF FIVE-YEAR COMPARISON

Between 2001 and 2005, the Diabetes Care category had the most measures that showed significant improvement than in any other health area. Screening and Control of Cholesterol LDL-C<130 mg/dL for plan members discharged alive after an acute myocardial infarction improved significantly since 2001 but at a lower rate than for members with diabetes. Maryland plans showed the greatest improvement on Adolescent Immunization Status than on any other measure (+29.9 percentage points). Nonetheless, in 2005 only slightly more than half of Maryland plan adolescents received their immunizations. Notably, none of the measures within the Behavioral Health Care category demonstrated a significant increase during the last five years.

Measuring Quality

DATA SOURCES

The HMO quality evaluation in this report is based primarily on two sources of data: the Health Plan Employer Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Measures are grouped into 6 categories of care and represent health maintenance (e.g., preventive care), member opinions, and clinical focus areas (e.g., diabetes care).

HEDIS

HEDIS is a standard set of performance measures developed by the National Committee for Quality Assurance to assess the quality of care delivered by a plan. HEDIS measures show the percentage of all HMO members who received a recommended service. Only the members who should have received each service during 2004 were included in calculating rates. That means the ideal rate for each HEDIS measure of service should approach 100 percent. For example, all children age 2 should receive the recommended set of immunizations. For these measures, a **higher rate always indicates higher quality**. An independent company hired by the State checked plans' methods for accuracy.

CAHPS

CAHPS is a standardized survey that measures members' experience with the care and service their plans provide. Areas addressed include the ability to obtain information from a health plan, the timeliness of services, and the perception of health care received. Taken together, the CAHPS results offer an indication of how well health plans are meeting their members' expectations.

Maryland plans participate annually in a survey of adult members using the CAHPS 3.0H questionnaire. An independent company hired by the State conducted the survey of 1,100 HMO/POS members randomly selected from each plan.

COMPARISONS TO THE REGION AND NATION*

In this report, aggregate performance of commercial HMOs is compared over time (2001–2005) and to regional and national averages in order to create a performance profile of Maryland plans.

Calculation of regional averages include HEDIS and CAHPS rates from 43 commercial HMOs in Washington, D.C., Delaware, Maryland, New Jersey, Pennsylvania, Virginia, and West Virginia that reported to NCQA in 2005. Table 3 below gives a summary of the demographics of these states and the nation. The national average is based on rates from 281 commercial HMO/POS plans. Both publicly reporting plans and non-publicly reporting plans (plans not identified individually in NCQA's public database) submitting HEDIS information to NCQA are included in the calculations.

COMPARISONS OVER TIME

Key improvements or declines in the performance of Maryland HMO/POS plans, in aggregate, for 2001–2005 are noted. Comparisons over time provide an assessment of the quality of services offered by Maryland plans and an opportunity to look at trends toward improved performance.

Table 3: United States and Regional Demographics (2004)

	Population Size	Age			Median Income	Number of HMO Plans
		Children 18 and Under	Adults 19–64	65+		
United States	290,286,350	27%	61%	24%	$44,473	414
Maryland	5,498,410	27%	62%	23%	$56,763	6
District of Columbia	548,140	21%	67%	23%	$43,003	5[1]
Delaware	820,390	26%	62%	25%	$50,152	4
New Jersey	8,613,040	27%	61%	24%	$56,772	12
Pennsylvania	12,153,290	25%	60%	30%	$44,286	14
Virginia	7,314,310	26%	62%	23%	$53,275	10
West Virginia	1,787,330	23%	61%	31%	$32,589	2

***Source:** Kaiser Family Foundation, 2004 (**www.statehealthfacts.org**)*
[1] District of Columbia plans' lives include lives for surrounding states.
** A t-test was used to determine whether the Maryland average was statistically different from the regional and national averages at the 95% confidence level.*

Children's Preventive Care

RESULTS

- **Childhood Immunization Status:** Maryland improved its performance for this measure outperforming the nation; however, the increase did not result in performance that was statistically better than the region. While immunization coverage among children in Maryland is high, it is vital to maintain these high levels to prevent a resurgence of vaccine-preventable diseases. Immunizations are one of the safest and most effective ways to protect children from a variety of potentially serious childhood diseases.
- **Adolescent Immunization Status:** Maryland plans continued to improve for this measure by 29.9 percentage points since 2001 but still lags behind the **Childhood Immunization Status** measure by 24 percentage points. Immunizations are just as important to adolescents as they are to children. The CDC and the American Academy of Pediatrics recommend that children receive a second dose of MMR, four hepatitis B vaccines, a tetanus booster and a chicken pox vaccine by the time they are 13 years old.
- **Children's Access to Primary Care Practitioners and Well-Child Visits:** Maryland continues to perform above the nation for these measures. In 2005, the Maryland average for the **Children's Access to Primary Care Practitioners** measures changed very little but performed above the nation for all three age groups for children. Maryland performance falls below the regional average for both the 25 months-6 years and the 7 to 11 year-old age groups. **Well-Child Visits in the First 15 months of Life** increased, keeping performance above the national average but falling short of the regional average by 2.7 percentage points.
- **Adolescents' Access to PCPs (ages 12–19) and Adolescent Well-Care Visits:** Maryland's performance on **Adolescent Access to PCPs (ages 12–19)** did not change in 2005, and Maryland continues to perform at the national average and below the regional average. **Adolescent Well-Care Visits** increased slightly to 38.4 percent, keeping pace with the nation but underperforming the region. Although adolescents have access to PCPs, many are not receiving a comprehensive well-care visit.

Public Health Focus — Childhood Immunizations

Before pertussis immunizations were available, nearly all children developed whooping cough. Prior to widespread pertussis immunization in the United States, between 150,000 and 260,000 cases were reported each year and there were up to 9,000 pertussis-related deaths (CDC, 2003). The DTaP vaccine for diphtheria, tetanus, and pertussis is normally given to children early in life; however, protection from the vaccine generally starts to wear off in 5 to 10 years. Over the last two decades there has been a rise in the number cases of pertussis in infants who have not received all of their immunizations and in adolescents and adults. Nearly 40 percent of whooping cough cases were seen in adolescents aged 10 to 19 years and approximately 19,000 cases were reported in 2004, a 63 percent increase from 2003 (CDC, 2005).

On average, 88 percent of children in Maryland plans received the DTaP vaccine (Comprehensive Performance Report, 2005). When compared to the national average, Maryland plans ranked above the nation; however, with the growing number of pertussis incidents over the past decade, these rates need to continue to increase.

PERFORMANCE COMPARISON

Table 4: Children's Preventive Care — Maryland Compared to the Region and Nation, 2005

Measure	Maryland	Region	Difference Between Maryland and Region	Maryland Performance Compared to Region	Nation	Difference Between Maryland and Nation	Maryland Performance Compared to Nation
Childhood Immunization Status (Combo 2)	77.1%	75.3%	1.8	↔	72.5%	4.6	↑
Children's Access to PCPs (Ages 12–24 months)	97.3%	97.2%	0.1	↔	96.7%	0.6	↑
Children's Access to PCPs (Ages 25 months–6 years)	89.4%	90.2%	-0.8	↓	88.1%	1.3	↑
Children's Access to PCPs (Ages 7–11 years)	89.5%	90.8%	-1.3	↓	88.5%	1.0	↑
Adolescents' Access to PCPs (Ages 12–19 years)	85.5%	88.0%	-2.5	↓	85.5%	0.0	↔
Well-Child Visits in the First 15 Months of Life	71.6%	74.3%	-2.7	↓	68.7%	2.9	↑
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	70.2%	73.2%	-3.0	↓	64.4%	5.8	↑
Adolescent Immunization Status (Combo 2)	53.1%	58.0%	-4.9	↓	46.9%	6.2	↑
Adolescent Well-Care Visits	38.4%	44.2%	-5.8	↓	38.3%	0.1	↔

Note: Measures are ranked in descending order by the difference between Maryland and the region. Differences are in percentage points.

Legend

↑ = Maryland HMO/POS average is higher than the regional/national average by a statistically significant margin
↔ = Maryland HMO/POS average is statistically equal to the regional/national average
↓ = Maryland HMO/POS average is lower than the regional/national average by a statistically significant margin

Measure Definitions

Well-Child Visits in the First 15 Months of Life — Percentage of children who had six or more well-child visits with a primary care practitioner during the first 15 months of life.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life — Percentage of children ages 3, 4, 5, or 6 who had one or more well-child visits with a primary care physician during 2004.

Children's Access to Primary Care Practitioners — Percentage of children:

- Ages 12–24 months and ages 25 months–6 years who had a visit with a primary care practitioner during 2004.
- Ages 7–11 years who had a visit with a primary care practitioner during 2003 or 2004.
- Ages 9–12 years who had a visit with a primary care practitioner during 2003 or 2004.

Adolescents' Access to Primary Care Practitioners — Percentage of adolescents ages 12–19 years who had a visit with a primary care practitioner during 2003 or 2004.

Adolescent Well-Care Visits — Percentage of adolescents ages 12–21 years who received at least one comprehensive well-care visit with a primary care provider during 2004.

Childhood Immunization Status (Combo 2) — Percentage of children who received immunizations by age two for: diphtheria, tetanus, and pertussis; IPV (polio); measles, mumps and rubella; hepatitis B; influenza type b; and chicken pox.

Adolescent Immunization Status (Combo 2) — Percentage of adolescents who received immunizations by age 13 for measles, mumps, and rubella, hepatitis B, and chicken pox.

Note: For more details regarding the measure specifications, refer to the 2005 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland or visit MHCC's Web site at ***http://mhcc.maryland.gov/consumerinfo/****.*

Adults' Preventive Care

RESULTS

- **Cervical Cancer Screening:** Maryland's performance for this measure did not change from 2004. Both the region and nation showed slight decreases, putting Maryland above the national average.
- **Chlamydia Screening:** Maryland plans continued to perform well above average compared to the region and the nation for this measure, resulting in Maryland plans screening more eligible women than plans do regionally and nationally. However, it remains the lowest of the screening rates.
- **Colorectal Cancer Screening:** Maryland continued to outperform both the region and the nation averaging 52.6 percent, although rates rose only slightly from 49.2 percent in 2004. Colorectal cancer screening rates are lower than other cancer screening rates included here.
- **Breast Cancer Screening:** Rates for this measure fell for Maryland and the region by 3 percentage points and for the nation by 2 percentage points. Debate over the effectiveness of mammography may contribute to confusion about how often — and whether — women should be screened for breast cancer. Researchers also suggest that decline in screening may be due to lack of mammographers, facilities, misreading of mammograms, or data collection practices. Raising awareness of the importance of early detection of breast cancer should be a priority. Mammography screening has been shown to reduce mortality by about 20 to 35 percent among women aged 50 and older, which is the age range for this measure (Elmore et al, 2005).
- **Prenatal — Postpartum Care:** This was the only adults' preventive care measure reported that showed a statistically significant improvement of 9.9 percentage points for **Prenatal Care** and 7.1 percentage points for **Postpartum Care**, from 2001–2005. Maryland is above the national average, but equal to the regional average for both measures.
- **Advising Smokers to Quit:** Maryland plans outperform the regional and national averages for this measure by 4.3 and 3.6 percentage points, respectively. Smokers who quit, on average live longer and have fewer years living with disability (U.S. Department of Health and Human Services, 2003). Quitting reduces the risk of smoking-related diseases, including lung cancer, heart disease, and chronic lung disease (Thun, 2000).

Public Health Focus — Colorectal Cancer

Colorectal cancer develops slowly and is often asymptomatic in its early stages, so early detection is particularly important and effective. If it is detected early (stage 1), 85–95 percent of patients with colorectal cancer can be cured, but if it is detected in a later stage, the average 5-year survival rate is 50 percent or less (Redailli, 2003). Over 56,000 deaths from colorectal cancer are expected to occur in the U.S. in 2005 (American Cancer Society, 2005).

In 2001, the Maryland legislature initiated a statute (MD. Code Ann., Health-Gen. §19-706 or MD. Code Ann., Insurance Article §15-873) mandating coverage of colorectal cancer screening. This mandate covers men and women over 50 and those under 50 who are at a higher risk. It covers colonoscopy screenings every 10 years, flexible sigmoidoscopy, double contrast barium enema screenings every 5 years, and annual fecal occult blood tests. In addition to these tests, the code references the American Cancer Society and its guidelines for colorectal cancer screenings. This makes the code flexible for future innovations in screening for colorectal cancer.

Maryland plans showed a slight increase in their rates of colorectal cancer screening since the inception of this measure in 2004. In 2005, the average rate for Maryland plans was 53 percent, a 4 percentage point increase from 2004 (Comprehensive Performance Report, 2005). Maryland ranks higher than both the region and the nation for this important screening test.

PERFORMANCE COMPARISON

Table 5: Adults' Preventive Care — Maryland Compared to the Region and Nation, 2005

Measure	Maryland	Region	Difference Between Maryland and Region	Maryland Performance Compared to Region	Nation	Difference Between Maryland and Nation	Maryland Performance Compared to Nation
Chlamydia Screening (Ages 16–25)	42.0%	30.7%	11.3	↑	32.2%	9.8	↑
Advising Smokers to Quit	73.1%	68.8%	4.3	↑	69.5%	3.6	↑
Colorectal Cancer Screening	52.6%	49.0%	3.6	↑	49.0%	3.6	↑
Cervical Cancer Screening	82.9%	81.4%	1.5	↔	80.9%	2.0	↑
Breast Cancer Screening	73.2%	72.2%	1.0	↔	73.4%	-0.2	↔
Postpartum Care	82.8%	81.8%	1.0	↔	80.6%	2.2	↑
Prenatal Care	92.5%	93.2%	-0.7	↔	90.8%	1.7	↑

Note: Measures are ranked in descending order by the difference between Maryland and the region. Differences are in percentage points.

Legend

↑ = Maryland HMO/POS average is higher than the regional/national average by a statistically significant margin
↔ = Maryland HMO/POS average is statistically equal to the regional/national average
↓ = Maryland HMO/POS average is lower than the regional/national average by a statistically significant margin

Measure Definitions

Breast Cancer Screening — Percentage of women ages 50–69 enrolled in a health plan who had at least one mammogram in the past two years.
Prenatal Care — Percentage of women beginning their prenatal care during their first trimester or within 42 days of enrollment if already pregnant at the time of enrollment.
Postpartum Care — Percentage of women who had a visit to a health care provider on or between 21 days and 56 days after delivery.
Chlamydia Screening — Percentage of sexually active women ages 16–25 who had at least one test for Chlamydia during 2004.
Cervical Cancer Screening — Percentage of women ages 18–64 who received one or more Pap tests within the past two years.
Colorectal Cancer Screening — Percentage of adults ages 50–80 who received a screening for colorectal cancer.
Advising Smokers to Quit — Percentage of members 18 and older who are either current smokers or recent quitters and who received advice to quit smoking from their practitioner.

Note: For more details regarding the measure specifications, refer to the 2005 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland or visit MHCC's Web site at ***http://mhcc.maryland.gov/consumerinfo/****.*

Diabetes Care

RESULTS

- Maryland now exceeds the regional performance for two of the seven **Comprehensive Diabetes Care** measures and is comparable with the region for the other five indictors. Maryland's performance compared to the nation remains unchanged from last year.
- **Cholesterol Control:** Maryland plans showed an increase over the prior year's rates in the average rate members had good control of their cholesterol at both levels by 5.1 and 7.1 percentage points, respectively. For this measure, Maryland outperformed the nation by 4.5 percentage points for the <130 mg/dL level and 5.1 percentage points for LDL-C level <100 mg/dL. Maryland plans moved above the regional plans for control at the <100 mg/dL level.
- **Blood Glucose Control and Testing:** The Maryland average for **Blood Glucose Testing** recovered this year after experiencing a decrease in 2004. The measure remained below the nation by 1.6 percentage points in 2005. **Blood Glucose Control** continued to increase slightly in 2005 but remains at the regional and national levels.
- **Eye Exams:** Maryland showed improvement in this measure performing 4.2 percentage points higher than the nation and moving above the region by 3.0 points this year.
- **Kidney Disease (Nephropathy) Monitoring:** This measure increased 4.9 percentage points this year to 52.8 percent, coinciding with smaller regional and national increases to remain at the regional and national averages.

Public Health Focus — Diabetes Care

Obesity and physical inactivity are highly associated with the development of type 2 diabetes. Between 1987 and 2000, obesity reached epidemic proportions in the United States, with more than 45 million adults classified as obese. In Maryland, adult obesity (body mass index [BMI] > 30) rates increased from 11.2 to 19.8 percent from 1991–2001 (CDC, 2005). It is estimated that in 2004, 20–24 percent of Marylanders were obese.

Type 2 diabetes is the most common form of diabetes affecting 90–95 percent of those with diabetes. Lifestyle changes, including exercise and a healthier diet, can prevent or delay the onset of type 2 diabetes.

Key policy recommendations include:

- Bolstering preventive care: Employers, including the government, could provide routine obesity-risk screening and more benefits for preventive care and obesity-related disease management.
- Leveraging change in food options: Major food purchasers could require a greater emphasis on nutritional value as a priority in the bidding process for food contracts arranged for cafeterias, public-assistance programs, and military meals.
- Providing more useful information and support: Federal, state, and local governments could provide more accessible, uniform, and constructive information to the public, extend and fully fund community-based obesity-reduction efforts, and forge stronger partnerships with private industry to support offering healthy options to consumers (The Trust for America's Health, 2005).

PERFORMANCE COMPARISON

Table 6: Diabetes Care — Maryland Compared to the Region and Nation, 2005

Measure	Maryland	Region	Difference Between Maryland and Region	Maryland Performance Compared to Region	Nation	Difference Between Maryland and Nation	Maryland Performance Compared to Nation
Eye Exams	55.2%	52.2%	3.0	↑	50.9%	4.3	↑
Cholesterol Control (Rate <100 mg/dL LDL-C Level)	45.3%	42.9%	2.4	↑	40.2%	5.1	↑
Cholesterol Control (Rate <130 mg/dL LDL-C Level)	69.3%	67.4%	1.9	↔	64.8%	4.5	↑
Kidney Disease (Nephropathy) Monitoring	52.8%	51.6%	1.2	↔	52.0%	0.8	↔
Blood Glucose Control	69.7%	69.9%	-0.2	↔	69.3%	0.4	↔
Cholesterol Testing	91.0%	91.7%	-0.7	↔	91.0%	0.0	↔
Blood Glucose Testing	84.9%	85.6%	-0.7	↔	86.5%	-1.6	↓

Note: Measures are ranked in descending order by the difference between Maryland and the region. Differences are in percentage points.

Legend

↑ = Maryland HMO/POS average is higher than the regional/national average by a statistically significant margin
↔ = Maryland HMO/POS average is statistically equal to the regional/national average
↓ = Maryland HMO/POS average is lower than the regional/national average by a statistically significant margin

Measure Definitions

Comprehensive Diabetes Care — Percentage of members with diabetes (type 1 and type 2), ages 18–75 who had: blood glucose (HbA1c) tested, blood glucose (HbA1c) controlled (≤9.0%), cholesterol (LDL-C) tested, cholesterol (LDL-C) controlled (<100 mg/dL and <130 mg/dL), eye exam (retinal) performed, and kidney disease (nephropathy) monitored.

Note: For more details regarding the measure specifications, refer to the 2005 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland or visit MHCC's Web site at ***http://mhcc.maryland.gov/consumerinfo/****.*

Cardiovascular Care

RESULTS

- **Cholesterol Management:** The Maryland plan average for **Cholesterol Management (LDL-C Screening)** increased by 2.7 percentage points to improve to the regional average but performance remains at the national average. Still, nearly one out of every five Maryland patients with an acute cardiovascular event is not being screened for high cholesterol after being discharged.
- **Controlling High Cholesterol:** An average of 72 percent of Maryland plan members had lab values that demonstrated cholesterol control at the <130 mg/dL level and 55 percent at the <100 mg/dL level. Maryland plans have increased the number of members identified as having acceptable cholesterol levels by 4.3 and 3.8 percentage points, respectively, but over a quarter of heart attack victims in the Maryland plans remain uncontrolled. High cholesterol is one of the principal modifiable risk factors for heart disease. Studies have shown cholesterol control to be especially critical for those who have suffered a first heart attack. Screening and management of serum cholesterol, especially low-density lipoprotein (LDL-C), is an important and effective way to reduce the suffering and disability caused by coronary heart disease.
- **Persistence of Beta-Blocker Treatment After a Heart Attack:** Maryland performs similar to the national and regional average for this new measure at 65.9 percent. This means that 34 percent of patients discharged alive after an acute myocardial infarction did not receive the recommended six months of treatment with beta blockers after their discharge. Nationally, if all heart attack survivors received timely beta-blocker therapy, an estimated 1,500 deaths could be averted each year; if they continued treatment for twenty years, 4,300 fewer chronic heart disease deaths and 3,500 fewer heart attacks would result (Philips et al, 2000).

Public Health Focus — Cholesteral Management After a Heart Attack

Coronary disease is the primary cause of death among adults during the peak of their productive lives and is the leading cause of premature, permanent disability in the United States labor force, accounting for 19 percent of disability allowances by the Social Security Administration (American Heart Association, 2005). Lowering cholesterol after a cardiac event can result in a 31 percent reduction in rates of fatal and nonfatal reinfarction and a 21 percent reduction in all causes of mortality (Malach, 2001). Effective cholesterol management can help reduce the huge economic burden of cardiovascular disease in the United States, estimated to be more than $393.5 billion in 2005, with heart disease accounting for $254.8 billion (Malach, 2001).

Although Maryland plans have shown an increase in cholesterol control for both the <130 mg/dL and the more stringent <100 mg/dL LDL-C levels, more can still be done, such as:

- increasing activities for blood cholesterol control at the state and community level;
- increasing worksite activities to reduce elevated blood cholesterol levels;
- developing program activities and products that are appropriate to the needs of minorities and other special populations and to actively involve health professionals and organizations that serve these populations; and
- promote increased dissemination of scientifically accurate cholesterol-related information by print and electronic media (National Heart, Lung, and Blood Institute, 2005).

PERFORMANCE COMPARISON

Table 7: Cardiovascular Care — Maryland Compared to the Region and Nation, 2005

Measure	Maryland	Region	Difference Between Maryland and Region	Maryland Performance Compared to Region	Nation	Difference Between Maryland and Nation	Maryland Performance Compared to Nation
Controlling High Cholesterol (Rate <100 mg/dL LDL-C Level)	55.7%	53.5%	2.2	↔	50.9%	4.8	↑
Controlling High Cholesterol (Rate <130 mg/dL LDL-C Level)	71.8%	70.8%	1.0	↔	67.9%	3.9	↑
Cholesterol Management (LDL-C Screening)	81.4%	82.9%	-1.5	↔	81.8%	-0.4	↔
Persistence of Beta-Blocker Treatment	65.9%	68.0%	-2.1	↔	67.4%	-1.5	↔

Note: Measures are ranked in descending order by the difference between Maryland and the region. Differences are in percentage points.

Legend

↑ = Maryland HMO/POS average is higher than the regional/national average by a statistically significant margin
↔ = Maryland HMO/POS average is statistically equal to the regional/national average
↓ = Maryland HMO/POS average is lower than the regional/national average by a statistically significant margin

Measure Definitions

Persistence of Beta-Blocker Treatment After A Heart Attack — Percentage of members ages 35 years and older who had a heart attack in 2004 and were dispensed a prescription for beta blockers covering a period of at least six months after discharge.

Cholesterol Management — Percentage of members ages 18–75 who were hospitalized for a heart attack or major heart procedure, who had a cholesterol screening, and whose cholesterol was under control (<100 mg/dL and <130 mg/dL) 365 days after the acute cardiovascular event.

Note: For more details regarding the measure specifications, refer to the 2005 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland or visit MHCC's Web site at ***http://mhcc.maryland.gov/consumerinfo/****.*

Asthma Management

RESULTS

- **Appropriate Medications for People with Asthma:** Rates for both age groups, Ages 5–17 and Ages 18–56, increased in 2005 by 4.1 and 2.9 percentage points, respectively, improving faster than the region and nation. Adults are receiving slightly better treatment for asthma than children or adolescents. Nonetheless, nearly a quarter of the nation's children and adults with persistent asthma are not receiving inhaled corticosteroids. This means for the 20 million Americans who are estimated to have asthma, about five million are not getting proper treatment (American Lung Association, 2005). Many asthma-related hospitalizations, emergency room visits, and missed work and school days can be avoided if patients have appropriate medications and medical management.

PERFORMANCE COMPARISON

Table 8: Asthma Management — Maryland Compared to the Region and Nation, 2005

Measure	Maryland	Region	Difference Between Maryland and Region	Maryland Performance Compared to Region	Nation	Difference Between Maryland and Nation	Maryland Performance Compared to Nation
Appropriate Medication for Adults with Asthma (Ages 18–56)	76.4%	74.5%	1.9	↑	73.8%	2.6	↑
Appropriate Medication for Children with Asthma (Ages 5–17)	72.8%	72.2%	0.6	↔	71.3%	1.5	↔

Note: Measures are ranked in descending order by the difference between Maryland and the region. Differences are in percentage points.

Legend

↑ = Maryland HMO/POS average is higher than the regional/national average by a statistically significant margin
↔ = Maryland HMO/POS average is statistically equal to the regional/national average
↓ = Maryland HMO/POS average is lower than the regional/national average by a statistically significant margin

Measure Definitions

Appropriate Medications for People with Asthma — Percentage of members ages 5–17 and 18–56 with persistent asthma who were prescribed medications acceptable as primary therapy for long-term control of persistent asthma.

Note: For more details regarding the measure specifications, refer to the 2005 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland or visit MHCC's Web site at ***http://mhcc.maryland.gov/consumerinfo/****.*

Public Health Focus — Asthma Management

In 2003, asthma affected approximately 20 million Americans and accounted for an estimated 12.8 million lost school days in children and 24.5 million lost work days in adults. Asthma ranks within the top ten prevalent conditions causing limitation of activity and costs our nation $16.1 billion in health care costs annually (American Lung Association, 2005).

In 2002, the Maryland Legislature established the Maryland Asthma Control Program (MD. Code Ann., Health-Gen. §13-1701-1706). This program seeks to:

- decrease the prevalence of asthma and the occurrence of its complications in Maryland through education, outreach, and surveillance; and
- decrease the disparity in health outcomes related to asthma by ensuring that people with asthma receive community-based care and services (Maryland Department of Health and Mental Hygiene, 2002).

Since 2001, Maryland plans have increased 12 percentage points for the Appropriate Medications for Children with Asthma (Ages 5–17) measure and 13 percentage points for the Appropriate Medications for Adults with Asthma (Ages 18–56) measure.

Behavioral Health Care

RESULTS

- **Antidepressant Medication Management:** Maryland plans performed below the regional average for two of the three measures, **Optimal Contacts** and **Continuation Phase**, which decreased in 2005 by 2.7 and 0.5 percentage points, respectively. Maryland performed at the regional and national average for the initial, **Acute Phase**, treatment period.
- **Follow-Up After Hospitalization for Mental Illness:** The Maryland average for **Within 7 days** measure fell below the region despite increasing by 2.6 percentage points, but still remains at the national average. Despite gaining 3.1 percentage points, the **Within 30 days** measure remained below regional and national averages. More than a quarter of members enrolled in Maryland plans and hospitalized for a mental illness did not receive follow-up visits within 30 days of their discharge.

PERFORMANCE COMPARISON

Table 9: Behavioral Health Care — Maryland Compared to the Region and Nation, 2005

Measure	Maryland	Region	Difference Between Maryland and Region	Maryland Performance Compared to Region	Nation	Difference Between Maryland and Nation	Maryland Performance Compared to Nation
ANTIDEPRESSANT MEDICATION MANAGEMENT							
Effective Acute Phase Treatment	62.3%	62.6%	-0.3	↔	60.9%	1.4	↔
Optimal Contacts	19.1%	21.2%	-2.1	↓	20.0%	-0.9	↔
Continuation Phase	42.8%	45.6%	-2.8	↓	44.3%	-1.5	↔
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS							
7 Days	55.5%	58.1%	-2.6	↓	55.9%	-0.4	↔
30 Days	73.3%	77.2%	-3.9	↓	75.9%	-2.6	↓

Note: Measures are ranked in descending order by the difference between Maryland and the region. Differences are in percentage points.

Legend

↑ = Maryland HMO/POS average is higher than the regional/national average by a statistically significant margin
↔ = Maryland HMO/POS average is statistically equal to the regional/national average
↓ = Maryland HMO/POS average is lower than the regional/national average by a statistically significant margin

Measure Definitions

Antidepressant Medication Management — Percentage of members ages 18 and older, newly diagnosed with depression, who had pharmacological management as denoted by 3 separate components: 1) optimal practitioner contacts for medication management during the 84-day acute treatment phase, 2) effective acute phase treatment during the entire 84-day acute treatment phase, and 3) effective continuation phase treatment of at least 180 days.

Follow-Up After Hospitalization for Mental Illness — Percentage of members ages six and older hospitalized for treatment of selected mental health disorders who were seen on an ambulatory basis or were in day/night treatment with a mental health provider within: 1) 7 days and 2) 30 days of hospital discharge.

Note: For more details regarding the measure specifications, refer to the 2005 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland or visit MHCC's Web site at http://mhcc.maryland.gov/consumerinfo/.

Public Health Focus — Alcohol and Drug Abuse

Substance abuse results in more deaths, illnesses and disabilities than from any other preventable health condition. Treatment for these conditions can be difficult, and many who enter treatment plans do not stay in long enough for them to be successful. Untreated addiction costs $400 billion per year in the United States, which is six times more expensive than heart disease and diabetes, and four times more than cancer (Brandeis University, Schneider Institute for Health Policy, 2001). According to the National Study on Public Perceptions of Alcoholism and Barriers to Treatment (1998), 82 percent of doctors indicate that they avoid addressing alcoholism in their patients. However, 72 percent of families say they need and want their doctor to address treatment.

Member Satisfaction

This section presents selected survey results of plan members based on the CAHPS 3.0H survey, a standardized set of survey questions that assess members' satisfaction with their experiences of health care. These results offer an indication of how well health plans are meeting their members' expectations.

RESULTS

- **Few Consumer Complaints:** On average, 13.7 percent of plan members reported that they had called or written their health plan with a complaint. This is the only member satisfaction measure included here that is statistically equal to the nation. All other measures are below the national average.
- **Rating of Health Plan:** Although this measure continued to be lower than other measures of satisfaction, Maryland's rate increased by 1.9 percentage points since 2004. The regional and national average also increased by the same amount. Thus, the Maryland average continues to be similar to the regional average but lower than the nation.
- **Getting Care Quickly and Rating of Health Care:** Maryland plans, on average, performed lower than the region and the nation for these two measures.
- **Rating of Health Care:** This measure continues to show the greatest difference between the Maryland average and both the regional and national averages; Maryland did not improve on this measure while the region and nation made small gains. Maryland performs significantly below these averages by 5.8 and 6.8 percentage points, respectively.

PERFORMANCE COMPARISON

Table 10: Member Satisfaction — Maryland Compared to the Region and Nation, 2005

Measure	Maryland	Region	Difference Between Maryland and Region	Maryland Performance Compared to Region	Nation	Difference Between Maryland and Nation	Maryland Performance Compared to Nation
Few Consumer Complaints	86.3%	85.5%	0.8	↔	86.3%	0.0	↔
Rating of Health Plan	36.4%	37.9%	-1.5	↔	38.4%	-2.0	↓
Getting Care Quickly	43.6%	45.7%	-2.1	↓	45.5%	-1.9	↓
Rating of Health Care	45.3%	51.1%	-5.8	↓	52.1%	-6.8	↓

Note: Measures are ranked in descending order by the difference between Maryland and the region. Differences are in percentage points.

Legend

↑ = Maryland HMO/POS average is higher than the regional/national average by a statistically significant margin
↔ = Maryland HMO/POS average is statistically equal to the regional/national average
↓ = Maryland HMO/POS average is lower than the regional/national average by a statistically significant margin

Measure Definitions

Few Consumer Complaints — Percentage of members who said "no, did not call or write my health plan with a complaint" in the last 12 months.

Getting Care Quickly — This is a composite of four related survey questions that ask members how quickly they received help, advice or care, got an appointment, or were examined. Percentage of members who said "always" to all four questions.

Rating of Health Plan — Percentage of members who rated their health plan "9 or 10" on a scale of 0–10, with 10 being the "best health plan possible."

Rating of Health Care — Percentage of members who rated overall care received "9 or 10" on a scale of 0–10, with 10 being the "best health care possible."

Note: For more details regarding the measure specifications, refer to the 2005 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland or visit MHCC's Web site at ***http://mhcc.maryland.gov/consumerinfo/****.*

Financial Picture

FINANCIAL STABILITY

Nationally, health care insurance premiums have risen steadily over the years: 13.9 percent from 2002 to 2003; 11.2 percent from 2003 to 2004. To offset their expenses, employers often increase employees' share of the costs (deductibles, copayments, coinsurance). The trend in cost sharing continues in 2005, although to a lesser degree than in the past (Health Affairs, 2005).

Several indicators of financial stability, when examined together, help explain the financial strength of a health plan. For a health plan to remain viable in the marketplace, it must perpetuate a financially strong balance sheet. Results of financial reviews of Maryland HMOs, as reported by A.M. Best Company (November 2005), are shown in Table 11.

Data shown for Maryland do not represent all companies domiciled in or operating within the State. The data represent a select number of health plans for the measurement year. East Region data are based on the HMOs domiciled and operating in the following states as of December 31 of the measurement year: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. Total Industry data are comprised of all commercial, Medicare, and Medicaid HMOs as of December 31 of the measurement year. The HMO population for the total industry numbers includes all geographic regions, including all for profit and non-profit HMOs, as well as all HMO model types including: staff, group, IPA, network, and mixed model.

The **Health Care Expense Ratio** is the total medical and hospital cost as a percentage of operating revenues, which exclude investment income and other revenues. The Maryland average health care expense ratio, which represents the seven plans in this report, continued to decrease for the fifth straight year, resulting in a 14 percentage point decrease since 2000. Both the eastern region and the total industry averages at 85 and 88 percent, respectively in 2004 show more stability with only slight changes of 3 and 1 percentage points from 2000 to 2004.

The **Administrative Expense Ratio** is the total administrative cost as a percentage of operating revenues. This ratio is influenced strongly by a plan's business mix. Plans with a large number of small groups and self-funded groups tend to have larger administrative expense ratios than plans with a large-group, risk-based membership. The Maryland average administrative expense ratio was 10 percent, which was slightly lower than the eastern region and the total industry, which were both at 11 percent. The administrative expense ratio has remained stable over time, averaging 10 percent between 2000–2004.

FINANCIAL RATING

Independent ratings are the global standard for assessing the financial strength of insurance companies. Verifying that an insurance company or HMO maintains sufficient resources to fulfill its ongoing commitments is vital information for purchasers and consumers. Information on a plan's financial strength helps purchasers and consumers make more informed health care purchasing decisions.

A.M. Best's financial strength ratings provide an independent opinion on the insurance organization's ability to meet its obligations to its membership by evaluating its balance sheet strength, operational performance, and business profiles. Four of the seven Maryland plans received a secure rating of A or A- on an A++ to F grading scale, with A++ being the highest rating. The three remaining plans rated in the B+ range (A.M. Best Company, July 2005). Secure ratings indicate that Maryland plans will be able to meet their obligations to members and policyholders and have a good chance of maintaining a level of financial strength that can withstand unfavorable changes in the business, economic, or regulatory environments.

Table 11: Five-Year Comparison of A.M. Best Financial Ratios for Maryland (2000–2004)

	2000	2001	2002	2003	2004
Health Care Expense Ratio	98%	91%	89%	86%	84%
Administrative Expense Ratio	13%	10%	10%	9%	10%

Maryland Performance Evaluation Guides

As part of its HMO quality and performance evaluation system, MHCC produces a series of reports covering commercial HMO performance. The series of four reports targets different audiences based on their interests and needs. In addition to this publication, MHCC produced the following annual HMO reports:

- *Measuring the Quality of Maryland HMOs and POS Plan: 2005 Consumer Guide* provides inter-plan comparisons on a subset of measures selected for their interest to people having or seeking insurance from commercial HMOs. This information is intended to assist consumers and purchasers in assessing the relative quality of services offered by commercial managed care plans. The *2005 Consumer Guide* was publicly released at a press conference on October 6, 2005. Approximately 100,000 *Guides* (in various forms) are provided to Marylanders when they choose their health insurance coverage each year, as well as to legislators and other stakeholders.
- The *2005 Comprehensive Performance Report: Commercial HMOs and Their POS Plans in Maryland* provides detailed data, including trending information, on the performance of Maryland HMOs across a large number of measures. The inclusion of more measures and greater detail allows academic, health care industry, and policy-making audiences to use the data for analytic purposes.
- *Measuring the Quality of Maryland HMOs and POS Plans: State Employee Guide* contains information that is similar to the *Consumer Guide* but contains only information regarding HMO/POS plans that are offered to state employees. (Available in 2006).

In addition to the publications listed above, MHCC, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, produces three Web-based, interactive Guides: *Maryland Nursing Home Performance Evaluation Guide*, *Maryland Hospital Performance Evaluation Guide*, and the *Maryland Ambulatory Surgery Facility Consumer Guide*. (Printed versions available.)

All Maryland Health Care Commission HMO/POS plan publications are available on the Internet at http://mhcc.maryland.gov/consumerinfo/.

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